New Jersey Department of Health and Senior Services

CREUTZFELDT-JAKOB DISEASE REPORT

Date	CDRS ID No.

Name (Last)	(First)	(MI)	Sex	Date of Birth (Age)

Street Address	County

City	State	Zip Code	Telephone Number

Race

☐ White ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American ☐ Asian ☐ Unknown/Other

Ethnicity

☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unknown

Reporting Physician (Name, Specialty, Address and Telephone No.)	Hospital (Name, Address and Telephone No.)

Date of Diagnosis	**Date of Illness Onset**	Case Classification	CJD Subtypes
____ / ____ / ____	____ / ____ / ____	☐ Possible	☐ Sporadic
Deceased?	**Date of Death**	☐ Probable	☐ Familial
☐ Yes ☐ No ☐ Unknown	____ / ____ / ____	☐ Confirmed	☐ Iatrogenic ☐ Variant

Clinical Features:

Progressive Dementia?	☐ Yes	☐ No	☐ Unknown
Psychiatric Symptoms?	☐ Yes	☐ No	☐ Unknown
Ataxia?	☐ Yes	☐ No	☐ Unknown
Myoclonus?	☐ Yes	☐ No	☐ Unknown
Akinetic Mutism?	☐ Yes	☐ No	☐ Unknown
Pyramidal / Extrapyramidal Dysfunction?	☐ Yes	☐ No	☐ Unknown
Did psychiatric symptoms precede onset of dementia?	☐ Yes	☐ No	☐ Unknown

Risk Factors:

Did patient have a risk factor for iatrogenic CJD (e.g., history of exposure to potentially contaminated neurosurgical equipment, corneal transplant, dura mater grafts, human-derived growth hormone)? ☐ Yes ☐ No ☐ Unknown

If yes, please specify risk factor: _____

Did patient live more than 6 months in Europe in last 10 years? ☐ Yes ☐ No ☐ Unknown

If yes, when: _____

Did patient have familial history of dementia? ☐ Yes ☐ No ☐ Unknown

If yes, please specify: _____

Laboratory Tests:

CSF examination date: ____ / ____ / ____

Protein: _____ WBC/mL: _____

Was CSF tested for presence of protein 14-3-3? ☐ Yes ☐ No

If yes, protein 14-3-3 present? ☐ Yes ☐ No

Was EEG examination performed: ☐ Yes ☐ No

If yes, does it show periodic or pseudoperiodic paroxysms of triphasic or sharp waves (0.5 to 2.0 Hz) against a slow background? ☐ Yes ☐ No

If no, specify what was observed: _____

_____

Was diagnosis confirmed by histopathological examination (brain biopsy or post-mortem examination)? ☐ Yes ☐ No

If yes, specify results: _____

_____

Name and Title of Person Submitting Report	Telephone Number